THE JOURNAL OF SCHOOL HEALTH

Vol. XXVI MAY, 1956 No. 5

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THE JOURNAL OF SCHOOL HEALTH

THE AMERICAN SCHOOL HEALTH ASSOCIATION

Chicago, Ill.

Published monthly, except July and August, at Buffalo, N. Y.

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Membership dues, $3.00 including Journal: Subscription $3.00

Single copies 35c, send payment with order

Address communications concerning publications

To THE EDITOR, The Journal of School Health

Room 617, 228 No. LaSalle St., Chicago, Ill.

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The American School Health Association

Entered as second-class matter at the Post Office at Buffalo, N. Y.
October 5, 1937

The Journal of School Health
is printed by
RAUCH & STOECKL PRINTING CO., INC.
120-130 ELMWOOD AVE., BUFFALO, N. Y. (near Allen)
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THE JOURNAL OF SCHOOL HEALTH

Devoted to the interests and advancement of school health service and instruction. Your participation by membership is solicited.

Vol. XXVI MAY, 1956 No. 5

ANALYSIS OF HEARING TESTS IN DENVER PUBLIC SCHOOLS

L. M. CORLISS, M.D., *Director of Health Service,*
VIRGINIA BREED, *Audiometrist,*
Denver Public Schools

In any school hearing program it is necessary to make a periodic analysis of test results to evaluate the efficiency of the testing procedure being used. The school system will then be able to utilize its funds and personnel to the best possible advantage as to frequency and grade level of the tests. This report is to summarize some of the data obtained in Denver schools during the last nine years.

I. *What Are the Routine Screening Procedures?* Each year individual pure-tone hearing tests are given to all of the children in certain grades, to children new to the Denver Public Schools and to those children with hearing deviation regardless of grade.

The frequencies screened are 250, 500, 1,000, 2,000, 4,000, and 8,000 at 15 decibels intensity. Audiograms are made for all children failing to hear two or more tones at 15 decibels. Approximately one class an hour can be done using this procedure. Testing the children one by one has the advantage of allowing the audiometrist to adapt the method of administering the test to the needs and ability of each child and, thus, obtain more accurate responses.

During February and March, 1956, the Glorig group audiometer has been tested in several of our schools. It is a pure-tone machine devised about a decade ago for military use that can test up to 40 individuals at a time. Results on several hundred 3rd, 5th, and 7th graders, and on about 1,000 high school students have been interesting and will be summarized in a subsequent paper. The Glorig audiometer is promising for mass screening in the larger school systems where there would be sufficient students to warrant the $2,000 to $3,000 cost of the equipment.

A nine year summary (Chart I) reveals the percent of hearing losses found each year since individual pure-tone audiometry has been done in the Denver Public Schools. Previous to 1946 group tests were done. There has been some variation in the grades tested but usually grades 1-3-7-10, or grades 1-3-5-7-10 have been

done. For *two* years the kindergartens and 12th grades were also done when time and staff allowed it.

(CHART I)

School Year	Total Tested	Number Defective	Percent Defective
1946-47	5,486	347	6.3%
1947-48	13,587	894	6.5%
1948-49	14,697	855	5.8%
1949-50	15,253	761	5.0%
1950-51	17,783	733	4.1%
1951-52*	22,032	1,027	4.7%
1952-53**	18,098	907	5.0%
1953-54	25,947	1,434	5.5%
1954-55**	30,394	1,634	5.4%

* Kindergarten and 12th grade pupils included.

** Twelfth grade pupils included.

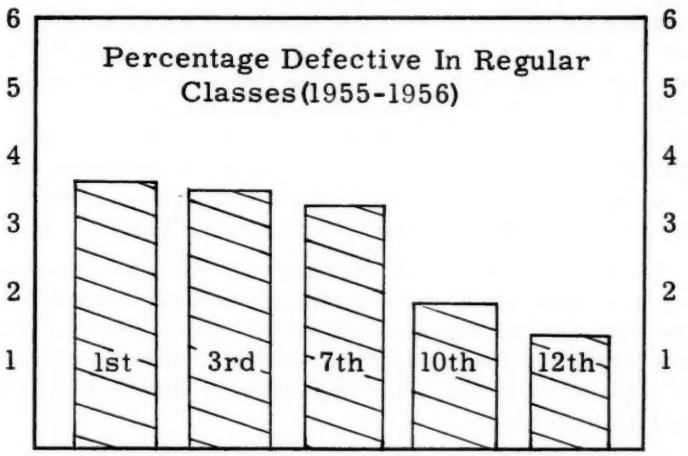
It can be seen from Chart I that the percent of loss is relatively stable in this nine year period in spite of the increasing number of pupils tested each year.

When data are based on the total number of pupils tested, the last two columns are abnormally weighted with defects since a large proportion of the group tested in the grades not routinely screened are children with known hearing losses that are routinely re-tested annually.

II. *Summary of Findings in 1954-55.* The grades 1-3-7-10 and 12 were screened and the results analyzed to see what percentage of hearing loss was found at each grade level. This detailed analysis on Chart II reveals the more accurate incidence of hearing defects because it avoids the abnormal weighting of the figures presented in Chart I. A total of 23,054 pupils tested in the above five grades of which 770, or 3.34%, were found to have significant hearing defects.

In the first grade, 6,858 children were tested and 260, or 3.8% had defective hearing. In the third grade 5,794 children were checked and 214, or 3.7% had hearing deviations. In the seventh grade, of 4,574 pupils tested, 156, or 3.4% were defective; of 3,010 tenth graders tested, 62, or 2.0% had a loss and 45, or 1.6% of the 2,785 twelfth graders tested had hearing losses. There were an additional 33 children at these age levels with sufficient hearing losses to cause their transfer from the above regular classes to our special program for those with severe hearing impairment. However, the percentage of defects in the total number of 1-3-7-10 and 12 grade pupils being tested in 1954-55 would be essentially the same if these 33 handicapped children were included for each grade level in this data.

(CHART II)



III. *How Often Should Routine Hearing Tests be Given?* Ideally, from an otologist's point of view, school children should have a hearing test each year. With a large school population, however, this is usually impractical and so the school system should decide how often the tests can be done efficiently, taking into consideration the money and testing personnel available. An analysis of test results will also give valuable information that can be used in evaluating the testing program. The analyses that follow were done to help us decide at what grade levels screening should take place in order to get the best possible results from our program.

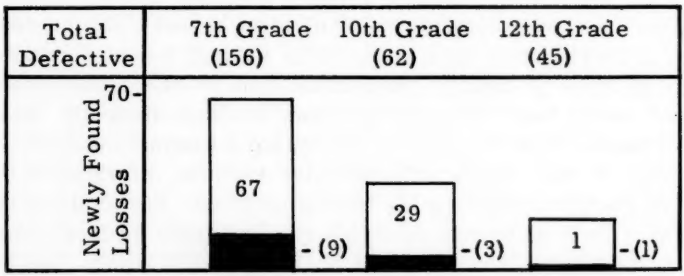
In 1951-52, the records of 6th grade students were analyzed to see at what grade level the most hearing deviations appeared. It was found that 179, or 89%, of the 201 children with defects through the 5th grade had developed their individual defect before the 3rd grade tests. For this reason we felt that the most valuable grades to screen in the elementary schools would be the 1st and 3rd grades.

An analysis was done of health records of 12th grade students of 1954-55, who had been in the Denver schools for all 12 years and had shown a hearing loss at one time. We hoped to discover what percentage of these defects occurred in the elementary grades and how many routine negative tests had preceded the one at

which the pupil was suspected of hearing loss. Of the 184 records which showed any deviation in hearing, 154, or 83%, of the defects were first detected during elementary grades and 87.7% of these were found at the first routine test. During the entire 12 grades, 145, or 78.8%, of the defects were found upon the initial testing. This analysis, though from a small sample, indicates the importance of testing new students at all grade levels, but especially during the elementary years where most of the hearing deviations seem to be first recognized.

We also wanted to know if pupils with newly found losses at the upper grade levels were children new to the Denver Public Schools this year or had been in the school system previous to this year's screening. If most of the newly found losses were children new to the school system, screening the entire 7th and 10th grades would not be necessary.

CHART III



The above table shows that merely testing high school pupils new to the school system is not entirely adequate and that screening of the 7th and 10th grades is desirable if time and staff allow. Only 15, or 0.5%, of the 2,785 12th grade pupils tested had losses not previously known to us. These results contra-indicate the need of testing the entire 12th grade.

IV. *Summary*

1. The majority of hearing defects develop before or during elementary school years and the incidence declines in the secondary grades. Most hearing deviations were found at the first test, indicating the importance of screening new pupils as well as those in certain grades.

2. Individual pure-tone audiometry is a satisfactory testing method and has yielded relatively stable results over the last nine years.

3. School systems should be encouraged to evaluate test procedures and results periodically to be sure they are doing the most efficient program.

* * * * *

STATEMENT ON SMOKING ISSUED BY AMERICAN HEART ASSOCIATION

Much greater knowledge is needed before conclusions can be drawn concerning possible relationships between tobacco smoking and increased death rates from coronary heart disease, according to a statement approved by the Executive Committee of the American Heart Association.

Currently, Dr. Page pointed out, definite knowledge on this subject is limited to laboratory and clinical evidence that smoking is harmful in certain diseases of the blood vessels of the arms and legs and it is recognized that tobacco may have an adverse effect on a small percentage of persons who already have coronary artery disease. Patients suffering from diseases of the heart and blood vessels were urged by Dr. Page to leave it to their physicians to decide whether smoking might be harmful to them.

* * * * *

HEART ASSOCIATION ANNOUNCES AWARD OF $830,000 TO 131 RESEARCH SCIENTISTS

Awards of $830,000 to 131 scientists engaged in cardiovascular research, for studies to be conducted during the twelve months beginning July 1, 1956, were announced in April, 1956, by the American Heart Association.

According to Dr. Irvine H. Page, Association President, the awards raise to more than $14,000,000 the sums allocated by the Heart Association and its affiliates for scientific research in the field of the heart and blood vessel diseases since the organization became a national voluntary health agency in 1948.

The awards announced today, said Dr. Page, provide for three Career Investigators, 64 Established Investigators and 64 Research Fellows, who will conduct their studies in 24 states, the District of Columbia, Great Britain, Greece and Denmark.

A SCHOOL-COMMUNITY HEALTH COUNCIL*

ARTHUR LEHNE, Ed.D.
Former Principal, Ericsson Elementary School
Chicago, Illinois

The Ericsson School-Community Health Council began to form in the fall of 1953 when parents and teachers concerned with the total on-going program of that sector of Chicago observed a need for more comprehensive and coordinated health program. It was then that the germ of the idea was planted but it was many months before the groundwork was laid that would serve as the successful foundation for an undertaking of this magnitude.

In the mosaic of communities that go to form a great city such as Chicago, problems vary greatly from one community to another. Not only is this true in the area of curriculum, abilities of pupils, rates of learning, but also in the realm of nutritional and health needs. That is why Chicago has moved closer and closer toward increased opportunity for local school-community planning.

Before an effective health council could be put into operation there was an evident need to study the school and community. Key members of the community, parents, teachers and the school principal undertook this study along with an attitudinal study to determine areas of concern. As might be expected the problem of health was recognized as significant.

Out of the tensions of a community experiencing significant changes in land use, an ethnic impact, changes in the community mobility pattern, changes in the density factor, and the substitution of a new culture and pattern of values, a challenge was introduced to the school.

Evidence of malnutrition in many homes, cases of pediculosis, ringworm, inadequate medical care and dental care caused concern to all who were able to recognize the problem. The low community response with the state health examination laws presented another index of apathy toward school-community health needs.

Certainly the solution to the problems of school health as well as the development of an awareness of these problems required the best thinking and co-ordinated efforts and cooperation of many agencies and individuals concerned with child welfare.

The first requisite of a health council is now presented: *a felt need.* The second and third requisites, namely *staffing* and *development of policy* can follow in logical order.

---

* Presented at the meeting of the School and College Health Services Section of the A.A.H.P.E.R., Chicago, March 26, 1956.

Staffing is quite simple. Ericsson School provided a representative group from the school iteself, teachers representing three different levels of instruction, an adjustment teacher, a physical education instructor, an attendance officer, a school engineer, a school principal and a lunch room manager. The community provided key parents who also functioned on the P.T.A., the Chicago Medical Association enlisted the aid of a local doctor and the Chicago Dental Association procured the services of a local dentist interested in the problems of school health. Leadership was provided through the Bureau of Health Services. A teacher nurse and the guidance of supervisors aided in initiating the program.

The program gathered steam as it went along. One starts by establishing ground rules or spheres of action, defines the purposes, seeks group solidarity, encourages individual and group thought and then within this framework moves on to the problems that the group perceives. Early problems approached might well be those to which solutions can be found within a reasonable span of time for "nothing succeeds like success." As perceptions become keener, long range problems should become a part of the focus.

An essential ingredient in the fabric of the health council such as we have in the Ericsson School is the necessary feedback between the council and the school-community — through the principal in the case of the school, and the P.T.A. in the case of the community.

A school health council — we wouldn't be without it!

* * * * *

NOTICE OF MEETINGS

This year the University of Missouri plans to hold the first of a series of annual conferences in special education.

A special Education Conference will be held as a part of the 1956 University of Missouri Summer Session. The conference will be held on June 21 and 22 and will be of interest to all teaching areas in special education and to those employed in allied service areas.

There will be three general sessions and a double series of sectional meetings. Speakers will include Dr. Bob Gates, Director of Special Education in the State of Florida; Dr. Samuel A. Kirk, Director of the Institute of Research for Exceptional Children at the University of Illinois; and Dr. Ray Graham, Director of Special Education for the State of Illinois.

THE SCHOOL NURSE AT WORK

EMMETT F. CAMBRON [1]

Chairman, Department of Health, Physical Education and Recreation, North Texas State College

Denton, Texas

The Texas Education Agency and the State Department of Health are to be commended for the co-operative leadership which they have given to the school people of the state. Their efforts have resulted in a better health program for the schools. An example is the recent development of a guide for school nurses which is proving to be of much benefit. The method by which the publication was developed is also of major import.

The agencies have demonstrated that any publication which is to be used in the schools is more readily accepted and is made more meaningful if it brings into involvement the people who are to use it. *The School Nurse at Work,* jointly issued by the Texas State Department of Health and the Texas Education Agency, is such a publication. Published by the Texas Education Agency in 1954, this bulletin was written as a result of requests made by school administrators in the state for professional assistance for newly employed school nurses.

In 1949, a decided impetus in the employment of registered nurses as members of regular school staffs was brought about by the passage of the Foundation School Program, known as the Gilmer-Aikin Bill. There has been a steady increase in the number of nurses employed in the schools of the state since 1949, when only a small number were to be found outside of the metropolitan areas. In September of 1955, there was an over-all total of 620 school nurses employed in 697 school districts in Texas. Of this number, 503 were in non-co-operative programs and 117 were in co-operative programs. There were 197 school districts in non-co-operative and approximately 500 districts in co-operative programs. Co-operative programs are those in which two or more districts join in the employment of a nurse or nurses.

A number of the nurses employed in the early 1950's had little preparation in public health or school health education. As a result,

1. Since preparing the enclosed article, I have read with interest the item on "Recommended Policies and Practices for School Nursing," as published in the January, 1956, issue of **The Journal of School Health.** I find that, although the Texas project and the work done by the National Committee of School Nurses for the American School Health Association were carried on independently and concurrently, they have much in common in their approaches to and solutions for the problem. Perhaps you would be interested in publishing the enclosed manuscript to provide information concerning how one state, Texas, is attempting to improve the program of nursing in the public schools.

these women had a terrific task. In some school districts, administrators would merely say to the nurse, "You are the school nurse, and there is a job to be done. You know more about this type of work than I do, so I am leaving the details in your hands; but, of course, let me know if you think I can be of assistance." Numerous requests were made by nurses to the Texas Education Agency and to the State Department of Health for help. These agencies endeavored to give essentially the same information pertaining to like questions, but in some instances it was contradictory. After getting their heads together, personnel from the two agencies thought it would be wise to have a joint committee composed of the State Department of Health and the Texas Education Agency to give study to the matter.

It was decided that the two agencies should prepare a bulletin, the primary purpose of which would be to suggest methods of organizing and conducting the work of the nurse in the school health program. In August of 1951, the joint committee asked a representative group of school superintendents and nurses to serve on a state-wide steering committee for the purpose of developing a guide for the school nurse. It was realized that for this information to be functional in the local district, it should have participants on the committee from the local level. Hence, seven public school superintendents and eight public school nurses were asked to serve. A chairman, who was a school health educator and who was actively engaged in teacher education, was named. A school nurse who was serving as supervisor of nurses in one of our larger school systems of the state was asked to serve as co-chairman. Four consultants — two from the State Department of Health and two from the Texas Education Agency — were also asked to serve. Thus, several points of view were brought into consideration in the preparation of the bulletin. As one consultant stated, "We need the ideas of many people in this project, and especially do we want consideration of two points — What is the total school health program? What is the nurse's part in the school health program?"

The first job of the steering committee was to record the types of information and materials which each member thought should become a part of the proposed bulletin. After the suggestions were tabulated, an outline was prepared.

Members of the steering committee were given the opportunity to work on any section they preferred. The response and the results were gratifying. After an interval, a meeting was

called for the purpose of editing submitted materials and preparing a rough draft of the guide. This was issued with the advice of superintendents, physicians, teachers, health educators, and others. Mimeographed copies of the draft were prepared and sent to committee members and to many people other than the ones who had participated in the making of it (approximately sixty interested and qualified people), inviting them to make additions, deletions, and/or suggested revisions. It was made known to all that the bulletin in its submitted form was not a finished product and that recommendations would be tabulated and presented with the individual reports to consultants from the two agencies who, with the chairman and the co-chairman, would revise the original manuscript. It also was made known that before publication, the bulletin would have to be approved by state medical and nursing associations, the state health officer, and the commissioner of education.

While work was progressing on the bulletin, consultants from the two agencies met with the chairman and the co-chairman on several occasions. Because of the great distances involved, it was not possible to have all members of the state-wide committee present at these meetings, but there was considerable correspondence with these people.

The bulletin finally evolved as Bulletin No. 561, *The School Nurse at Work*, a 70-page publication. The foreword was written by the two chief officers mentioned above. Steering committee members were listed, and an introduction was written by one of the consultants working on the project. The organization and administration of the school health program, the objectives of the school health program, planning of the school health program, and factors in determining nursing activities, were discussed briefly. A discussion of the role of the nurse in the school health program made up the major part of the publication, and was presented in five sections, titled as follows:

Section 1—The Nurse's Duties and Responsibilities.
Section II—The Nurse's Role in School Health Services.
Section III—The Nurse's Role in Health Instruction.
Section IV—The Nurse's Role in Healthful School Living.
Section V—Supplementary Forms and Information.

The school nurses in Texas have done a remarkable job in the school health programs of the state during the past few years. Many have taken courses recommended by their professional organizations, in areas such as public health, sociology, psychology,

and human development. A number have received college degrees. The school health program certainly presents a much more encouraging picture today, state-wise, than was true in 1949.

One of the committee members who worked on the bulletin wrote that she had enjoyed working on *The School Nurse at Work* as much as any experience of her professional career, and stated that what impressed her most about the preparation of this publication was "the great number of people who were involved in the writing of the material." She further stated: "I was impressed by the contribution made by the classroom teacher, the school nurse, and the superintendent to the entire study." It is felt by several who participated in the study that the effectiveness of the bulletin has been enhanced by the method utilized in its production.

Continued study will be given to this bulletin and its utilization by nurses, administrators, and other professional people who are particularly concerned with the health work of the schools. It is the consensus that when there is a need for a revision, the State Department of Health and the Texas Education Agency will again join hands in the accomplishment of another co-operative project.

* * * * *

NEWS AND NOTES

COUNCIL ON RHEUMATIC FEVER AND CONGENITAL HEART DISEASE

The American School Health Association is one of the eleven founding organizations of the American Council on Rheumatic Fever and Congential Heart Disease. The annual meeting of the Council will be held in Cincinnati, Ohio, October 29th.

Bernice Wedum, M.D., has been our Representative on the Council for the past decade. Her reports to the Association in its annual meetings and through our Journal have been quite helpful to the membership.

She requests that members of the Association who have encountered problems in the cardiac child write her at the following address:

Bernice Wedum, M.D.
The Yater Clinic
1801 K Street NW
Washington, D. C.

A. O. DeWEESE, M.D.

LET'S HIRE A HEALTH COORDINATOR

A Comparative Study of School Health Educaton in Two Suburban Communities

WINFIELD G. DOYLE, Ed.D.

Curator of Education, Cleveland Health Museum

Over twenty thousand young people received formal health instruction from the Department of Education at the Cleveland Health Museum in the school year of 1954-55. Of these, several hundred were from the eleven schools in a suburb of Cleveland which, for discretionary reasons, we shall call Little Valley.

Another suburb, which we shall call Knollton, shares many notable characteristics with Little Valley. Both enjoy a high income level among their residents; both are purely residential; and both have fine school systems. The chief difference between the two is size. This is reflected in school populaton. Knollton had 11,366 pupils enrolled last year, while Little Valley had 6030.

With the establishment of a Museum Department of Education in 1951, it soon became evident that the Little Valley and Knollton school systems could make better and more extensive use of Museum facilities. It was the belief that this could best be achieved by appointing health educators to their staffs and assigning them to the Museum. After nearly two years of exploration and discussion, Little Valley did add a health coordinator to its staff. Knollton, on the other hand, became involved with complex administrative and curriculum problems and to date has not made any firm decision about a health educator.

It is significant that the health coordinator hired by Little Valley had seen prior service as a health educator on the Health Museum staff and was therefore thoroughly acquainted with its operation, its exhibits and perhaps, most important, with the methods used in museum education.

Before and After: In the school year of 1952-53, when neither Little Valley nor Knollton employed a health educator, Little Valley sent 34 classes to the Health Museum, and Knollton sent 28.

Two years later, Little Valley sent 82 classes to the Museum while Knollton sent 29 classes, essentially the same attendance as in previous years. In terms of numbers of classes, Little Valley had increased its Museum attendance by over 241% in two years.

Both Little Valley and Knollton offer an excellent course of study, "The Art of Personal Living," at the fifth grade level. The course content was drawn up originally by the Family Health Association and taught by their instructors in the classroom. Today, some health classes in these two suburbs are still taught by Family Health Association instructors, while many others are conducted by the regular classroom teachers. The course runs the gamut of health concepts and includes study of all the organ systems of the body. It winds up with a unit on maturation. Here is where the Health Museum has entered the picture prominently. With its excellent collection of birth models and other exhibits dealing with the reproductive system with its films, and with its trained staff of health educators to teach the subject factually and without emotional overtones, the Health Museum is a logical community resource for the schools to use in this unit of study.

Of the 52 Little Valley classes mentioned above, 46% were fifth-graders. Of the 29 Knollton classes, 59% were fifth-graders. In other words, with the addition of a health coordinator to the Little Valley schools, Health Museum visits were not confined principally to fifth-graders as they were in Knollton; there was a more representative attendance from the other grades. This meant that a wide range of health subjects could be presented to the Little Valley children: nutrition, heart and circulation, rest and sleep, good grooming, mental health, human reproduction.

Briefly summarized, then, the addition of a health coordinator in Little Valley has made possible (1) more classes visiting the Health Museum, (2) a greater representation of all elementary grades, and (3) more diverse kinds of health lessons. Knollton, on the other hand, has conformed to its attendance pattern of previous years, with most of the emphasis on visits by fifth-graders.

Demonstration Lessons: Another important phase of the Little Valley health coordinator's work has been special demonstration lessons in the classroom. There were 94 such lessons during the past year, and they were given for all elementary grades and in all elementary schools.

The joy and genuine enthusiasm generated in Little Valley's school children by these health demonstrations is almost unbelievable. The explanation for it is no secret. Mr. Health Coordinator is a warm, interesting person; children like him. He knows his subject thoroughly. He has succeeded in collecting items for these lessons which have a high-interest quotient.

Among the devices he uses is a series of suitcase exhibits. These were developed at the Health Museum for use by the class-room teacher.[1] Many of them incorporate viewer participation, such as pushing a button or swinging a flap to one side. Others contain dissectible models like a tooth, heart, and ear. These features, combined with their bright colors and simple design, make the suitcase exhibits a delight to children. In the hands of a skillful instructor, they can add new vitality to any health lesson.

In-Service Training: Mr. Health Coordinator's most important contribution, aside from his teaching program, has probably been the in-service training he has conducted for class-room teachers. He has done this by example and individual counseling rather than by a special course labeled "In-Service Training in Health Education." For instance, in the spring of 1955, he was able to prepare teachers for the Salk vaccine program, and through his own efforts and those of the teachers he counseled, many of the fears "of the needle" the youngsters had were allayed. This, obviously, is an on-going program, and each year there is a measurable improvement in health education in the Little Valley schools as a result of this in-service training.

A Partnership "Almost Unique": The relationship that exists between the Cleveland Health Museum and the Little Valley schools is almost unique—if something can be "almost unique." There are two reasons for this: the paucity of health museums generally in the United States, and the fact that Little Valley is one of two school systems that have this kind of arrangement.

So far as we know, the other two health museums — those in Dallas and Philadelphia — have no teachers or other staff from the public schools assigned to them.

At the Cleveland Health Museum, a teacher from the Cleveland Board of Education has been assigned for the past five years. Because of the size of the system (111,122 pupils in 168 buildings), the nature of his work is quite different from that of Mr. Health Coordinator in Little Valley, although he follows the same general pattern of conducting classes from the Cleveland schools through the Museum, and visiting classrooms for special lessons based on Museum materials.

Consequently, the pattern for health museums is unique, but it should be quickly added that many similar cases could be cited for other types of museums.

Your Health Coordinator's Job: It is all very well, you may be thinking, to talk about a school-museum partnership of this kind, but what of the cities that have no health museum? Would a health coordinator be as effective there as in Little Valley?

A health coordinator added to your staff can do much to set your health education house in order. There is altogether too little health education being offered in our schools, and much of what is being taught is of inferior quality. In a recent study of school health practices involving 150 schools in Bergen County, New Jersey, it was found that 64% of the schools teach health only one period a week, and that in 40% of the schools, health is taught not as a separate course but as part of physical education.[2] This is a good program compared to others that could be cited.

Probably the best prerequisite a health coordinator can have is a graduate degree (Master of Public Health) from one of the schools of public health. Such a person, brought into your school system, knows the latest methods, has the most up-to-date information, and is familiar with the best in curriculum. He can assist in coordinating your health services with your instructional program, and he can supplement whatever regular classroom teaching you now do with classroom demonstrations of the type given in Little Valley. He can plan field trips to the health department, to a hospital, to a sewage disposal plant, to a rehabilitation center, or any of a dozen other community agencies with a health lesson in them. He can provide principals and teachers with information about films, slides, posters, charts, and other visual aids in health and with the techniques for using them. He can conduct in-service training that will raise the whole level of your teaching program. He can be a liaison between your staff and parents where health matters are concerned. He can participate in community programs and even organize new ones where needed. And he can carry out assignments that meet specific local needs.

A complete job description for the health coordinator was published recently in this Journal.[3] There is also a description in the book, "Health Education,"[4] highly recommended for launching a health education program in a school system where it does not already exist.

So if you are a school superintendent and have been saying: "Let's hire a health coordinator — or should we?", you can confidently forget the last three words and pull a contract from your

desk. Based on our experience with the Cleveland and the Little Valley Board of Education, when provision is made for a health coordinator in a school system, both the quality and the quantity of school health education can be tremendously improved.

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NEWS AND NOTES

Dr. Bruno Gebhard, director of the Cleveland Health Museum, announces that the Cleveland Foundation has awarded a grant of $22,000 to the Museum to be used over a two-year period. The money was allocated to assist in the creation of two new exhibits entitled "Mental Health" and "Heredity in Health and Disease," as well as to expand the staff of the education department.

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NEW NURSING GUIDE

We have been happy to present the new guide "Recommended Policies and Practices for School Nursing" as it appeared in the January issue of the Journal. The response to the guide, thus far, has far exceeded our fondest hopes. As stated in the January issue, it does not represent a finished product. Since we hope to make it as useful as possible we would greatly appreciate your reactions. Please send me your comments, your suggestions and your recommendations. If any nurse has achieved unusual success in any area mentioned in the guide or would like to share her experiences with others we hope she will write an article for the Journal. Thank you.

IRMA B. FRICKE, R.N., Chairman
School Nursing Committee
American School Health Association

A PARENT'S VIEW OF THE COLLEGE HEALTH PROGRAM*

ROBERT O. YOHO, M.A.

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Indianapolis, Indiana

Parents of young adults often tell me their problems. One of them told me this story.

"My son John enrolled at a small private coeducational college in southern Indiana in September of this year. Two months later, he became 18 years old, and, consequently, was eligible for military service. I mention this only for the purpose of indicating that he has, or is approaching an age when, in the eyes of society, he is mature enough to assume adult responsibilities.

"That which he has experienced to this time in home, school and community, and that which happens to him during his college life, will determine to a great extent, how effectively and completely he fulfills his responsibilities as an individual and as a member of society. The responsibilities of my son with which we are concerned in this instance are those related to personal and community health.

"No unusual circumstances were associated with John's birth. During his first year, he was immunized against diphtheria, smallpox and whooping cough. He had an occasional cold, and received a regulation basketball as his first birthday gift. This is not uncommon in Indiana, especially when the father happens to be a coach.

"John's sister was born during his third year of life and he learned to accept her as an important member of the family.

"He was taken, and I stress, taken, to our physician for regular check-ups and sat in the dentist's chair before he began to lose his baby teeth.

"Before starting to grade school for the first time, he had a complete medical and dental check-up and received his booster shots. Despite all this, he was absent from school 45 days during his first year, as a result of having measles, mumps, chickenpox, influenza and an ear infection. From this experience, one might question the effectiveness of the school's communicable control program. One might even speculate that it was non-existent.

* Presented at Tri-State College Health Conference, Highland Park, Illinois, March 2 and 3, 1956.

"Sometime during the late elementary grades, my son began going to the dentist by himself. We made the appointments. During his junior year in high school, he became completely responsible for his own dental health. He, with the help of his dentist, set up a schedule of periodic visits. In addition, when minor injuries have occurred, he has taken it upon himself to see our family physician.

"We have tried to provide our son with a healthful environment in which to grow up. Much of this has been accomplished with very little effort since pure water and adequate sewage systems were available. However, it has required some effort on our part to provide clean, wholesome, properly stored, refrigerated and prepared food.

"Some effort and thought were involved in making it possible for him to get the necessary amount of rest and sleep and, provide an atmosphere conducive to concentration when he studied. Fortunately, John's dietary, sleep and rest practices have never presented much of a problem. I am of the opinion that this resulted from his interest in basketball and baseball rather than the home influence.

"Incidentally, when John was 16, his brother was born. I was unable to make one single visit to the hospital without John accompanying me. By John's choice, when he is home from college, he shares a room with his brother.

"I have recounted these events in my son's life in order to demonstrate that each experience was a part of the maturation process. Gradually, he has progressed from having all his health needs taken care of by his family to the point where he meets many of them himself, but not all. In a sense, we have been his health supervisor. Supervision has been gradually relinquished as proficiency and willingness to assume personal responsibility have been demonstrated.

"Since my son is now away from home and living in a men's residence hall with 340 other young men of his age, I would like him to continue to have the same general kind of health supervision that he has had in the past. I would like the objectives of that supervision to be much the same as that in the past. Control those things which he cannot control as an individual and help him assume further individual responsibility for those aspects of health over which he can exercise personal control.

"Naturally, the environment in which he now lives is quite different than it was when he lived at home, but basically, the problems of health which he faces as a college student are the same.

"Living intimately with approximately 300 young men creates problems which call for college control. Under these conditions, the proper atmosphere for study, rest and sleep cannot be left to chance. The possibility of the spread of communicable, contagious and infectious diseases is increased and unless the college introduces effective preventive and control measures, my son's health is endangered.

"Meals are taken in the communal dining hall and I expect the college to assure nutritious and wholesome food served in an inviting manner. I expect that the food served be secured from reputable sources and that it be stored, refrigerated and prepared under safe and sanitary conditions. A departure from this is inexcusable.

"I would not be adverse to his developing from his communal eating experience, additional table etiquette. May I suggest, too, that some thought be given to the college boy's midnight snack and its effect on health. As far as I can determine, it now consists of "pizza and tamales."

"In case of accident or illness, I would like the college health service to provide the necessary first aid and emergency care and advise me as to further action necessary. If the situation is such that immediate action is necessary, or my son's family cannot be contacted, then I would hope and expect the health service personnel to exercise their own best judgment as to the course of action to be pursued.

"It would be most gratifying if I might receive an occasional report from the college health service as to John's general health practices and status. Frankly, I would be as interested in this as in "smoke-ups" and semester grades. In fact, such information might partially explain those 'C's.'

"*In Summary*: The college health service occupies, in many respects, an ideal position to promote good basic attitudes toward health and illness. The college physician knows well the age group with which he is dealing, and represents an involvement that is free of the emotionalism of parents and a quality of service not affected by income.

"On the other hand, the college physician is frequently regarded with suspicion. Students, parents and other physicians frequently wonder why, if he is qualified, he is not in private practice. Parents and students expect him to be another old family Dr. Jones (M.D. 2 yr. Med. College 1901) whose medical outlook and therapy have not changed since graduation. Or they may expect him to

give the same care and service that they have learned to expect from their plush, well-equipped and adequately-staffed clinics back home.

"Parents and the college health service can agree that for the good of all:

1. There should be an accurate statement as to what services are available, how these services are financed and the responsibilities of parents and students.
2. The college physician should be competent, approachable and interested in students.
3. The health service should be able to help the student in selecting his personal physician.
4. Medication should only be given after examination and diagnosis.
5. The health service staff should take time to give individual counseling and guidance related to health habits, care of self and protection of others during illness.
6. The health service personnel, as well as others in the college health program, should be especially alert to tuberculosis.

"Finally, I hope that my son's contact with the college health service will be an educational experience and that from this experience, he will be better prepared to fulfill his responsibilities for his own and his community's health and that he will not expect his government or social agencies to do those things for him which he can do better for himself."

Make Your Reservations Early for the

ANNUAL MEETING OF THE AMERICAN SCHOOL HEALTH ASSOCIATION

at Atlantic City

NOVEMBER 12-16, 1956

Headquarters — Claridge Hotel

HOW UPPER MERION TOWNSHIP INTERPRETS ITS SCHOOL HEALTH RESPONSIBILITIES*

ROBERT D. MAY, M.D.

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In general the Pennsylvania State School Health Program is a plan which has been devised by the joint efforts of the State Department of Health and by the local Physicians, for the sole purpose of safeguarding the physical and mental health of the school children in this state. The state officials outlined the original plan but it has been well buffed by the caustic practicality of the men who have operated under this plan over the years — the local physicians. In general the plan calls for a medical history on each school child, which parents provide during the child's first term; physical examination of each school child at specified intervals; certain laboratory work as is deemed advisable by the school physician; inspection and testing by the nurse on certain matters; and finally correction of any defect detected in these school children by the parents through their own doctor. In addition the general plan calls for certain sanitary inspection, certain supervision as regards the school age athletes, and certain educational efforts on matters medical, and certain obligations in respect to communicable diseases, etc.

Specifically this is a working outline of the school health program for Upper Merion. The center of our interest is the child. The child's mental and physical health and development are molded by these influences:

1. Parents
2. Teachers and school authorities
3. School medical personnel

Each has a responsibility to the child, and all have a responsibility to each other.

Now let's see what the teacher's role is:

A) Teachers are the eyes, ears and brain of the school doctor, the school nurse, and often the school age child's parents. They are with the child more hours than any of the above. If they are keen enough they are the first to notice Mary's lack of attention, which may indicate incipient blindness or early deafness, and which may be related to a rare but operable brain tumor, or to an inadequacy of vision correctable with simple glasses. If they detect this defect

*Recent address to group of school nurses, Upper Merion Township.

early, perhaps we may save a child's life, but in any event, if it is glasses that Mary needs, their detective work will be rewarded, for a Mary who can see will be much less of a problem for them to teach than a Mary who cannot.

The same facts apply to those children with mental and emotional problems. If they detect them, we may be able to help resolve them, and here again the child will benefit, but also, the teacher will benefit by having one less problem child with whom to deal.

B) The teachers also share with nurses the responsibility for health education of the child in this county. I wonder if you nurses have ever stopped to think that you and the teachers are the authority for health education in most families, by virtue of this responsibility?

C) Athletics are supervised by teachers as part of their responsibility in most schools. This is a most important phase of development in all boys and girls, yet it is a heavy responsibility for them to carry. I know that none of our athletic supervisors would be particularly pleased with their job if any child under their direction were permanently maimed while engaged in sports in school. It is most important that these supervisors be able to rely on the nurse for expert opinion as to who should play, what, and how long.

Teachers are important to any health program in three ways:

1. As detectives to uncover mental and physical defects.

2. As teachers to uncover truths and present them as such.

3. And as athletic directors, to supervise safe athletics by safe athletes.

Nurses are intimately concerned with all three phases:

1. By educating teachers to look for defects and reminding them of this obligation.

2. By teaching teachers and children truths about health matters.

3. By helping supervise the athletic directors and insisting they provide safe athletics for all.

I will not bore you with the listing of the duties of a school nurse as prescribed by the state. These will be more familiar to you than to me. I would rather discuss the obligations of a school nurse from the doctor's standpoint.

The school nurse must be a dedicated professional person with unique capabilities and capacities for management and maintenance.

A good school nurse is a professional servant. She will not allow her personal feelings to enter into a relationship with the physician, the teachers, the students, or any outside person during working hours.

A good school nurse is a person. She is not a machine despite the fact that we require of her a tremendous amount of management, organization, filling in forms, doing a hundred and one other chores which must be done. A good school nurse never loses sight of the fact that she is a genuine thinking, feeling person with a sincere and deep respect for the problems of the children whom she serves.

Finally, all of these attributes are of no avail if they occur for one fleeting moment at the beginning of the school year. The school nurse must contain the ability and the desire to get afloat and stay afloat. She must be willing and able to manage and maintain.

A good school nurse is essential for the management and accomplishment of any decent school health program. All of you know your duties. It is hoped that my definition and discussion will help you to achieve and enjoy these duties to the fullest. As a school doctor there is nothing more refreshing than to work with a good school nurse, and there is nothing more heart-rending and harrowing than to work with a poor school nurse.

The school doctor's duties are defined by the state as follows:

1. To be available daily, on call, or at a designated time and place for the examination of children suspected by teachers or school nurse of having a communicable disease. The disease, if confirmed, is to be reported to teachers, parents, and health authorities.

2. To make careful classroom inspections for communicable diseases or infectious conditions prevalent in the school district.

3. To make a complete sanitary inspection of all school buildings, classrooms, toilets, cafeterias, etc., and report on findings.

4. To call attention to any condition of heating, ventilation, or general cleanliness which might be a health hazard.

5. To examine all pupils coming into the district and to vaccinate those who cannot afford it.

6. To examine all children who are working part time.

7. To examine all children who are entering into training for athletics and evaluate their physical fitness and report their eligibility for participation in the sport of their choice.

8. To examine every child in the first, third, seventh, and eleventh grades yearly.

9. To examine all school employees and teachers every second year. This includes cafeteria help, janitors, bus drivers, etc.

10. Record all results on state forms, and issue notices of advice regarding defects. (Nurse or medical secretary may do this.)

11. To take charge of all authorized campaigns for the use of protective procedures, such as vaccination, etc.

12. Finally, he must be available from time to time to lecture to the teachers of the district on the health program. He shall assist the physical directors, school nurses, dental hygienist. He shall cooperate in the use of proven mechanical devices for testing hearing. (In most schools the nurse does numbers 1,2,3,4 and 5.) I would also like to suggest that more school nurses do the actual vision and hearing test on these children for the obvious reason that they know the children better than does the school doctor. It is absurd to say that they are not properly trained to do this work.

Now as to the *parent's role in a health program.* Despite the fact that it sometimes appears that the parents of our school children are negligent in assuming the proper share of their responsibility for the mental and physical health of the children in our school system, such is not the case. It has been our experience that most parents are not only delighted to assume their personal share of this responsibility, but will cooperate to such an extent that they will assume the obligations of those who are unwilling or who are unable to do so, provided they are shown the need and are taught what to do. Parental cooperation cannot be obtained with a pink slip hurriedly checked with a suspected defect and sent home by a messenger. There must be a certain amount of stimulation of the parents to excite their desire to cooperate and this can only be done by pleasant personal professional contact of the parent by the school nurse, the school doctor, the school dentist, or even the medical secretary if she is well trained.

One phase of a local health program I should like to review and re-emphasize is the education phase. Each influential group should be prepared to provide every child with education along the lines most important to him — and that is, "what is good and normal in health and development, and in what ways are the good and normal to be fostered?" This should be the job of the parents, teachers, and school health personnel.

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COMMON SKIN DISORDERS SEEN IN THE PUBLIC SCHOOLS AND THEIR TREATMENT*

EARL D. OSBORNE, M.D.
Buffalo, N. Y.

Impetigo: —the treatment of impetigo contagiosa is ridiculously simple today—soap and water twice a day and the application of a water solution of neomycine (200 milligrams in 8 oz. of water)—that will handle 98 per cent of cases. And if they don't react to neomycin, you can use neosporin ointment.

Warts: —are due to a virus. If I were to give one piece of advice to children in schools, I would say: "Wear wooden clogs, or any kind of slippers, but never walk in your bare feet."

Molluscum Contagiosum: —is not uncommon in school children. It is a virus infection and spreads by contact. The cure is very simple—take a curette—press down on the central body and it will pop right out and you then sterilize the base with merthiolate, metaphen, or some similar disinfectant.

Pityriasis Rosea: —one of our most common skin diseases. The lesions are oval and the long axis of the oval is along the lines of cleavage of the skin. They follow, *in general*, the distribution of the sensory nerves. This disease looks serious. However, it gets well spontaneously in six or seven weeks. Use a little plain Calamine Lotion. No further treatment is suggested.

Psoriasis: —is absolutely not infectious and non-contagious. There is no reason why a child with psoriasis shouldn't go to school.

Flea Bites: —very common condition in children today and the diagnosis is missed in well over 90% of the cases. There are discrete lesions—little hard, round, red patches with a *central*

* Excerpts from address to School Physicians and Nurses at Lake Placid, June 6, 1955.

punctum. One person in 30-35 is susceptible or becomes susceptible. The eggs of a flea will live for as long as 22 months in rugs, carpets and blankets. DDT spray around the home—DDT bomb in the closets. A sothing lotion, calamine, may be used locally on the skin.

Head Lice: —Key diagnosis is not necessarily in finding the nits. When you see a dermatitis on the back of the neck—under the hair—look for the nits in the scalp. Use an all-purpose parasiticide. One application is all that is necessary. These preparations contain Benzyl Benzoate 10%, DDT 2%, and 1% Benzocaine in an emulsion base. (The trade name for the most widely used product is Lilly's Topocide.) Wash head thoroughly with soap and water —leave it moist and then put on a good soaking with Topocide. Put cap on and leave it on overnight. Wash hair the next morning. Benzocaine kills nits. They loosen and come away.

Acne: —Blackheads occur when the pores are filled with keratin (containing sulphur) and sebaceous material, and exposure to the air turns them black (forms sulphides). They are not due to failure to wash the face. Acne is due to a hormonal imbalance and the treatment is with estrogenic substances—not by diet.

Ringworm: —Insist on adequate drying and powdering of the feet and aeration. This will do more than anything else in the world to prevent ringworm of the feet. You do not need to use the pans containing sodium hypochlorite at all.

Seborrheic Dermatitis: —70% of all cases of external otitis are due to primary seborrheic dermatitis of the scalp. Clean up the scalp and the ears get better of their own accord.

Moles: —Any brown mole, that *doesn't have hair* in it, is a potentially dangerous mole. If, in addition to that, it is in a location subject to irritation, it is doubly dangerous. Hairy moles never become malignant.

Penicillin on the skin: —There is no indication for the use of penicillin on the skin. It should never be used, because it is a sensitizer. We need penicillin for more serious disease. The same is true of sulpha drugs. We don't need to use these drugs since there are many which are so much better. Remember neomycin, panmycin, terramycin, aureomycin, neosporin—any of a dozen or so.